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BUILDING A HEALTHY FUTURE: REACHING YOUTH AT RISK

Project Summary

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INTRODUCTION

Health communicators and policymakers continue to grapple with how to address the needs of young people who engage in high-risk health behaviors such as alcohol and other drug use, early and unprotected sex, and violence. To help meet these needs, several Federal agencies sponsored a project to develop health promotion strategies and approaches for communicating health information to hard-to-reach, high-risk youth. The project was directed by the U.S. Department of Health and Human Services' Public Health Service (PHS) and assisted by a Federal Advisory Panel.

The project included 24 focus groups throughout the country with 160 youth already engaged in high-risk health behaviors, 8 discussion groups with families of high-risk youth, and discussions with representatives of national youth organizations and local youth programs. Based on these efforts, PHS has identified strategies and made recommendations for policymakers, communication professionals, and youth services program staff when they create programs and campaigns to help decrease high-risk health behaviors among these youth and to promote healthful behaviors. This summary provides an overview of the findings from the focus group discussions.

This project corroborates the findings of other recent research projects on adolescents conducted by the Carnegie Council on Adolescent Development, Office for Substance Abuse Prevention (DHHS), the Office of Technology Assessment, and the Robert Wood Johnson Foundation.[1]

It is not too late to develop prevention programs for youth. Many people recognize the importance of getting young children off to a good healthy start, for example, in programs such as Head Start. With adolescents, however, many interventions do not become available until after there is a problem. Youth are still forming the attitudes and behaviors that will carry them into adulthood. Acting now to develop prevention programs will get them there safely.

A critical element for planning and policy development related to prevention emerged from this project: the voice of youth. This project confirmed the complexity of the behaviors and environments surrounding high-risk youth. There will be no simple solution. The answers lie in multifaceted, multilevel, long-term commitments to prevention for youth at risk.

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[1] See Linda Bass, "Changing Course: When Formative Evaluation Suggests a New Program Direction," a report on the Urban Youth Campaign of the Office for Substance Abuse Prevention, Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services, presented June 5, 1992; Fred M. Hechinger, *Fateful Choices, Healthy Youth for the 21st Century*, New York, Carnegie Council on Adolescent Development, Carnegie Corporation of New York, 1992; Congress of the United States, Office of Technology Assessment, *Adolescent Health*, vols. I and II, Washington DC, U.S. Government Printing Office, April 1991; MEE Productions Inc., *Reaching the Hip-Hop Generation*, a report to the Robert Wood Johnson Foundation, Philadelphia, May 1992; and Carnegie Council on Adolescent Development, *A Matter of Time: Risk and Opportunity in the Non-School Hours*, a report of the Task Force on Youth Development and Community Programs, New York, December 1992.

BACKGROUND

The focus groups with high-risk youth examined their knowledge and practices regarding health risk behaviors.[2] "High-risk" youth were defined as those who have already engaged in health risk behaviors and who do not consistently participate in mainstream health services or attend schools. The groups included youth ages 10 to 18, separated by age, ethnicity, and gender. African American, Native American, Mexican American, and white youth participated.

The majority of the participants lived in households receiving public assistance. Nearly half were from single-parent households; some lived in group homes, with other relatives, or in foster homes. A large majority were truants or school drop-ins or drop-outs. Approximately one-third were involved in alcohol and other drug use or had arrest records. Adult supervisors reported that nearly half belonged to gangs and that two-thirds had parents who were alcohol or other drug abusers.

To explore what youth reported from an adult perspective, the findings were shared in discussions with families selected from the same neighborhoods as the youth in the earlier focus groups.

Full representation of all racial/ethnic groups was not achieved due to a variety of obstacles and "real world" limitations, for example, recruitment, moderator availability, resources. Hispanic groups were conducted only with Mexican American youth, and no groups were conducted with Asian and Pacific Islander Americans. Similar obstacles and limitations also affected adequate geographic and rural representation within the focus groups. Further study is needed to gather insights into these groups and to develop a more complete understanding of youth in high-risk situations.

SUMMARY OF FINDINGS

Findings are summarized for the youth groups, family groups, and representatives of groups serving youth.

YOUTH GROUPS

Findings from the youth groups are summarized under two topics: *Communication: Channels and Messages* and *Views of Health and Life*.

Communication: Channels and Messages. The focus groups yielded insights about the ways in which high-risk youth obtain and process information about health risk behaviors. Key findings include:

- Youth relied on family and friends for information about health. Although youth turned to mass media outlets for information and entertainment, personal sources were their primary credible source of such information.
- Family, in all of its configurations and despite its sometimes negative influence, was very important to these young people.
- Young people were eager for personal interactions with adults who listen in a nonjudgmental manner.

[2] As with all qualitative research, focus groups do not use scientifically valid sampling procedures. The results cannot be statistically extrapolated to any population. Rather, such findings are intended to help identify issues of special concern to high risk-youth, what they believe to be important, and the challenging circumstances in which they live.

- ❒ Youth received mixed messages from both the media and from adults about how they should behave and what behavior is acceptable.

- ❒ Youth were sensitive to any ethnic and racial stereotypes, even those conveyed unintentionally by public service announcements.

Interpersonal sources and channels. Although they relied on mass media outlets—primarily television and radio—for information and entertainment, they were more likely to trust information garnered from family and friends. Personal sources were repeatedly named as youth's primary credible source of information.

The mass media, however, were a source of intended and unintended messages. For example, in addition to the information received from public service campaigns, youth learned from commercials, news, and entertainment programs, such as "The Cosby Show." These youth were a perceptive audience, tuned in not only to the storyline but to the subtext.

Importance of family. For these youth, "family" included parents, grandparents, aunts, uncles, and even friends. The family in all of its forms was repeatedly named as a source of day-to-day support, direction, and emotional nurturing. In addition, the family was cited as the primary credible source for information. Conversely, for many the family also was the source of alcohol and other drugs and weapons.

Personal interaction. The focus group process itself reached high-risk youth. One of the most important findings was the way the participants reacted to the focus group itself. Youth valued the opportunity to talk openly to an adult. In addition, they spoke about how much they had "learned" during the groups even though nothing was "taught." Youth seemed to value the process of being able to talk about their lives and analyze certain behaviors and consequences without being judged.

Mixed messages. Youth reported that they often received contradictory messages from adults. For example, although youth were told not to smoke, they often encountered adults who smoked. Youth were influenced not only by what adults tell them to do but also by adults' behavior.

Product promotion was another source of confusion. Although public education messages encouraged healthful behaviors, advertising of alcohol and cigarettes directly or indirectly promoted unhealthy lifestyles. Youth did not receive clear and consistent messages that these behaviors are dangerous, unacceptable, and often illegal (for those under age). As a consequence, they found the messages to be both confusing and hypocritical.

Racial and ethnic stereotypes. Youth were sensitive to racial and ethnic stereotypes. One Native American youth, describing a public service announcement, said, "I didn't like that they showed all Indians in poverty. Everybody's poor, whoever's an Indian. . . . They make us look like we're all drunks." Youth were quick to note the importance of hearing messages that do not promote stereotypical images of any racial or ethnic group but do provide positive images of people like themselves.

Views of Health and Life. As youth discussed health issues and described their daily routines, a picture emerged of a well-informed population without the skills necessary to apply this information to their own lives. Youth:

- ❒ Accurately described all health risk behaviors and issues and their consequences, except HIV/AIDS.
- ❒ Linked behaviors, often associating one risk behavior, such as drinking, with another, such as sexual activity.
- ❒ Considered most risk behaviors as normal and acceptable.
- ❒ Had a great deal of discretionary, unsupervised time in which to engage in these behaviors.
- ❒ Lived in communities where violence is a way of life.

Risk behaviors were understood. With the exception of HIV/AIDS, youth were well informed about health issues (such as smoking, pregnancy, and alcohol and other drug use). They were particularly confused about "safe sex" and the difference between practices to prevent HIV/AIDS and practices to prevent pregnancy. Their level of awareness indicated that mass media and other channels do reach them. Youth understood that these health messages alone would not change someone's behavior but believed the messages should be continued so the information would be available when someone is ready to change.

Many were ambivalent about the "good" and "bad" outcomes associated with risk behaviors. For example, although they realized that smoking caused cancer, they smoked to fit in with their peers. Although some knew how difficult life could be for a teenage parent, many echoed a female who said, "Having a baby is the best thing in your life."

Risk behaviors were inextricably linked. Youth did not segregate risk behaviors but linked them. They did not discuss one risk behavior in isolation from others. Youth said that engaging in one behavior often led to another; several behaviors often occurred simultaneously. For example, drugs were often a precursor to initiating or having sex, and alcohol might be consumed to enhance courage when fighting.

Youth had time for risk behaviors. The youth's daily lives were characterized by lack of adult supervision and lack of positive alternatives to high-risk behaviors. Many were out of school or unemployed and had few responsibilities. Most gave vague descriptions of typical days in their lives. For most, a typical day consisted of "waiting to see what will happen." They enjoyed a great deal of free time without adult supervision. Few had significant responsibilities, either in the home, in the workplace, or in school.

Risk behaviors were the norm. High-risk behaviors were the norm not only among youth but among their families and in their communities. Often, home and family were the source of alcohol and other drugs and weapons.

Youth deemed many behaviors, such as early sexual activity, normal or appropriate for individuals their age. A majority said sex is acceptable for teens, as are fighting and using alcohol and other drugs. Only violence was viewed as a true threat. Many expressed concern about the violence that permeates their lives.

Violence was overwhelming and pervasive. In urban settings, violence had an overwhelming influence and presence in these youth's lives. For African Americans and Mexican Americans who live in cities where gangs are powerful, violence was endemic. Gangs dictated all aspects of their lives, from who lived or died to what color they could wear. Gang involvement was nearly impossible to avoid, and quitting was not perceived as an option.

Youth had access to a spectrum of weapons, especially guns, which they supplemented with various homemade weapons. For many, weapons were available at home or could be rented for one night.

Youth were skeptical about their ability to avoid violence. Good communication and conflict resolution skills alone were insufficient. One youth said, "You can't just walk away, it comes after you." When asked, many did not believe they would live to be 16 years old.

When asked if health messages using fear appeals are effective, African American youth responded, "No." They said the fear portrayed on television PSAs, for example, is no match for the fear they experience in real life. Consequently, these types of messages have no impact.

Changing risk behaviors. Youth offered advice on what would work in changing the views of people about health issues. Their ideas consistently emphasized talking one-on-one, telling people "straight out" about the consequences of risk behaviors, and showing how it is with "real people." The need to "talk it out" with a trusted source was mentioned in all of the groups.

FAMILY GROUPS

In these groups, families from the same communities as the youth discussed their perspectives on what influences the behavior of the youth, their perspectives on what the youth said in the focus groups, and the role of adults and communities in preventing or changing risky behaviors.

Interpersonal sources. Parents cited their children's friends and peers, the media and popular culture, and the schools as having the greatest influence on their children. They also named themselves and considered their influence to be more positive than that of their children's friends and peers.

Although adults generally agreed with youth's statements that families are a source of information about risk behaviors, they felt that peers are a more important source. In addition, there were differences in whether families provide any information about sex. Many said their children turn to friends, schools, or the media for information about sex. One parent stated, "I sat my 9-year-old down and told him about sex because he came home from school and said somebody told him a condom was something you eat." Many parents did not initiate conversations about sexual behaviors and only broached the subject if their children brought it up first.

Role of the family. According to the adults, in general, the role of parents and families in preventing risk behaviors has been compromised by the power of peer pressure and by youth's extensively unstructured, unsupervised time. Other barriers to preventing risk behavior include broken families and two-career families, situations that lead to youth having too much unstructured time. However, parents also noted that rebellion is a part of growing up and that they expect their teenagers to rebel in some way.

Many adults said that they need more and better community services and programs to help prevent youth from becoming involved in risk behaviors. One parent noted, "If we as a community don't take an interest in these kids, these are the same kids who are gonna be breaking into our house." Several parents reported that gaps in their own knowledge, especially about AIDS and how to be a good role model for youth, make it difficult for them to deal with some of the issues discussed.

Mixed messages. Adults recognized that youth receive conflicting messages about appropriate health behavior, especially from family members who drink, smoke, or use drugs. Although some participants believed youth could and should learn from their own mistakes, many recognized that today those mistakes—unprotected sex, drug use—could prove fatal. Some reported that their children had asked them to stop smoking or drinking.

Adults agreed with youth's report that families were often the source of drugs, alcohol, and weapons, citing extended family members as the most likely source. Many parents appeared to be concerned with their children having access to weapons and drugs but did not seem to feel such a sense of urgency about youth's access to alcohol.

Adults agreed with the youth that the racial and ethnic stereotypes sometimes portrayed in PSAs reinforced negative images.

Risk behaviors understood. Adults confirmed what young people had said in focus groups. They added that some young people are aware of the health risks associated with certain behaviors but do not want or know how to change their behavior.

Time for risk behaviors. Adults reported wide variation in youth supervision. Several said they supervise their children "24 hours a day, 7 days a week." Some reported spending as much as 4 or 5 hours each day with their children; others reported spending as little as a half hour. Interactions revolved around their children's household and scholastic responsibilities, primarily chores and homework.

Personal interactions. Parents appreciated that young people want adults to whom they can talk in a nonjudgmental way but felt that doing so with their own children compromised their parental authority. They felt that it is not possible—or appropriate—for parents to be buddies as well as authority figures.

REPRESENTATIVES OF YOUTH SERVING GROUPS

The representatives from groups serving youth confirmed and embellished on what youth and families said. They lamented decreases in funding for recreational and athletic activities, saying that youth often have nowhere to go after school. They talked about reduced funding for social and health services and stated that there are not enough summer jobs to go around. The findings are categorized into two topics: *Understanding the Needs of the Family* and *Supporting the Role of the Family*.

UNDERSTANDING THE NEEDS OF THE FAMILY

With respect to families, the youth advocates believed that family support has weakened. More parents are unemployed. When youth must help provide financial support to the family, there is little incentive for parents to force them to be in school. Participants stated that some parents must work two or more jobs and are rarely at home. Other parents were addicted to drugs or incarcerated. When adults in a family were dysfunctional, positive health behavior on the part of their children would disrupt normative behavior in family. Participants further stated that, in some cases, gangs had taken on the role of family. They noted that basic family needs (for example, for food, shelter, and jobs) must be met before families could provide support for their children.

SUPPORTING THE ROLE OF THE FAMILY

Participants stated that parents and caretakers need to learn basic parenting skills and have information about normal behavioral and developmental stages. They also need to be taught verbal and listening skills. All agreed that getting parents to participate is difficult because they have other pressing concerns such as jobs.

Participants reported that many parents know less about health risk behaviors than their children, who learned about them in school. Therefore, youth are being asked to have skills that their parents do not have. They stated that parents need to learn communication and parenting skills and the same health-related information their children are being taught in school.

Mixed messages. Participants confirmed that mixed messages are presented which send confusing signals to youth. Examples of mixed messages include community programs that accept funding from corporations that sell tobacco and alcohol, expectations for youth to behave in ways that adults do not, and penalties for emulating "adult" behaviors. Participants stated that youth need skills to acknowledge and assess the meaning of mixed messages for their own behavior.

Participants also stated that some values held by society and some families also represent mixed messages to youth. For instance, some families value jobs more than education. For these families, getting through school may not be valued, and some parents may not have the skills to help their children make it through school.

Personal interactions. Participants confirmed that many youth may not want to talk with their parents. These youth need safe places where they can talk about issues that concern them as well as solutions to their problems.

Violence. In discussing their perceptions about these youth, the participants reported that youth are threatened by violence inside and outside of school and believe they could not afford to appear "weak" to others. Youth do not feel protected by the police. Police feel this tension among youth and do not know what to do. Some of these youth have no fear of the criminal justice system or even of death, feeling that they have nothing to lose. And where youth are fatalistic about the future, threats of consequences from current risk behaviors are of little value.

Sustaining youth programs. Families stated that there is a need to sustain programs for youth. For every day that a program operated, youth received some attention and health care and spent one less day in the street. However, short-term funding and piecing together categorical funding sources into a program were cited as causes of strain on programs and program staff. Program representatives further noted that short-term funding has resulted in skepticism within many neighborhoods. Residents do not trust new programs, believing that they will soon be gone.

Participants felt that youth's distrust is apparent when the public health community or other government agencies are unable to provide promised health services.

Giving youth and families a meaningful role. Participants stated that there is a need to involve both parents and youth in planning, delivery, and evaluation of community services to ensure that such services address the most important needs of the recipients. Also important is involving parents and youth in service delivery (for example, as youth volunteers).

Participants stated that youth should be considered resources within the community. When organized and encouraged, the youth can provide community services such as working with elderly people. They felt that using youth leaders to recruit other youth to volunteer is a way to increase involvement in community service.

Participants stated that youth need to learn critical thinking skills and need to be exposed to alternative environments and lifestyles; for example, youth could be trained to be health advocates and outreach workers and to perform certain skills such as CPR. Youth could participate in community service projects, but resources are needed to organize and maintain such projects. Youth also need to be provided with incentives and benefits to participate such as stipends, school credit, or court-mandated community service credit.

COMMUNICATION AND PROGRAM IMPLICATIONS

These findings and those of the other reports indicate that adolescents cannot be reached by communication alone. Facts are not sufficient to influence behavior. Youth need opportunities to process and discuss health issues with caring adults in order to understand the importance of the information to their own lives. The implications for communication and program planners are significant. Preliminary strategies are highlighted below.

- ❒ The influence of families should be considered in any program designed to reach high-risk youth.
- ❒ Communication campaigns should be integrated with programs and services to provide the personal interaction necessary to change behavior.
- ❒ Just as high-risk youth link risk behaviors (smoking with drug use, for example), risk-related programs and services should be integrated. A comprehensive approach must be taken to address multiple risk behaviors.
- ❒ To avoid racial and ethnic stereotypes, messages and programs should be culturally sensitive and competent. Messages must be accurate and should suggest ways for youth to use the information provided to them. Messages also should be developmentally appropriate.

INVOLVE THE FAMILY

In developing strategies to reach youth, program planners should not overlook the influence of the family. Social and domestic programs should involve, not circumvent the family. Although families can be a source of youth's problems, they also are an important element through which solutions can evolve.

Programs should focus on how to reach families. To change the behaviors of these youth, the behaviors of the families also should be changed. Parents and other caregivers need to understand the consequences of health risk behaviors so that they are prepared to reinforce and validate health messages accurately. Treatment and intervention, as well as support and information, are needed to help parents and other caregivers be positive role models.

Programs should give parents and other adults information and resources to empower them to help their children. These adults should:

- ❒ Have accurate information about risk behavior and normal adolescent development and be able to understand the clustering of health-compromising risk behaviors.
- ❒ Have access to services such as training in parenting and English-language skills, and substance abuse treatment.

- ❒ Have an understanding of the impact of their behaviors on their children and the mixed messages those behaviors may send.

- ❒ Be encouraged to participate in community efforts that improve neighborhood safety or that offer structured (but relevant and appealing) activities for youth.

DEVELOP APPROPRIATE MESSAGES

Youth are sensitive to subtle cultural messages and racial stereotyping. Thus, messages and programs should be culturally competent, diverse, and sensitive but also should provide positive images. Campaigns should strive to maintain a balanced representation of all races and ethnicities. Risky health behaviors are not just a minority issue. Such approaches will lessen the likelihood of promoting racial and ethnic stereotypes.

Program planners need to consider the information needs of youth at different ages and developmental stages. A 10-year-old requires a different level of information than does a 17-year-old.

These findings underscore the importance of pretesting messages and campaigns with target audiences. The ultimate goal is to find out what information members of the target audience need, develop a program or campaign to get this information to them, and then assess whether the intended message was received and acted upon. Pretesting helps in achieving this goal.

INTEGRATE MESSAGES WITH SERVICES

Youth stated what health communication professionals already know: Information alone cannot motivate change. Messages should point to an action that young people can take to begin to change their behavior. Youth also should be offered opportunities to synthesize and apply what they have learned. Programs in schools, community organizations, and health institutions should reinforce these messages.

Although mass media can raise awareness and provide information, messages delivered through this channel alone are not enough. Programs should enable youth to understand and personalize information so they can use it to maintain their health.

Youth should have access to resources that encourage them to incorporate healthy behaviors in their own lives. These resources should sustain change. Broad programs designed to promote healthy behavior should take into account the need for long-term attention to be able to meet youth's needs over the course of years.

SPONSOR COMPREHENSIVE PROGRAMS AND SERVICES

Youth do not categorize risk behaviors: One often accompanies another. Categorical approaches—smoking addressed in one program, alcohol in another—do not speak to youth because they do not reflect the reality of young people's attitudes or behaviors. Nor do they reflect the reality of the environment in which youth live, where one behavior is often inextricably linked to another. Thus, programs that address risk behaviors should be integrated and comprehensive to enhance their appeal, relevance, and potential effectiveness for high-risk youth. However, further investigation would be helpful in confirming which behaviors are linked and therefore could be addressed effectively together.

POLICY IMPLICATIONS

Taken together, all the findings and preliminary program recommendations suggested a range of policy implications. Representatives of national youth organizations, foundations supporting youth programs, and local youth programs provided additional suggestions for identifying policy needs at national, State, and community levels.

NATIONAL POLICY NEEDS

- ❒ Promotion of integrated services among social services, education, welfare, and alcohol and other drug abuse treatment agencies, for both youth and their families.

- ❒ Removal of barriers to collaborative funding of comprehensive programs for youth at risk. Strategies to encourage collaboration such as joint grant announcements and joint technical assistance delivery by individual agencies.

- ❒ Review of national policies impacting youth and families to ensure consistent support for integrated, comprehensive programs.

- ❒ Incentives for the development of programs that integrate communication and services at the State and local level.

- ❒ Central coordinating point at the Federal level to facilitate joint activities and mitigate policy discrepancies.

STATE/LOCAL POLICY NEEDS

- ❒ Health education curricula that address health issues in a comprehensive, not categorical manner.

- ❒ Mechanisms to blend categorical funding streams and permit collaborative funding of comprehensive programs for youth at risk.

- ❒ Identification and removal of barriers to integrated services, such as reporting requirements, regulations governing facilities, and staffing requirements, to ease access and use by high-risk youth and their families.

- ❒ Incorporation of individualized adult guidance and attention into service delivery programs for high-risk youth.

POLICY NEEDS AT ALL LEVELS

- ❒ Policies that build, strengthen, and support community-based programs.

- ❒ Policies that emphasize youth and family input into the design of programs and services and allocate resources to allow communities to plan services tailored to meet the specific needs of high-risk youth and their families within their communities.

- ❒ Policies that integrate communication into programs and services.

- ❒ Policies that recognize services needed for parents and families of high-risk youth such as training in parenting and English-language skills and substance abuse treatment.

- ❒ Policies that encourage support for safe havens and productive activities for youth as alternatives to high-risk behaviors.

- ❒ Policies that build adult guidance and personal attention into services for youth.

- ❒ Policies that limit youth access to weapons.

- ❒ Policies that address society's mixed messages to youth (such as alcohol advertising to underage youth).

Reaching youth in high-risk situations requires health professionals to continue to listen to and involve these youth and their families. This project has raised many issues that need further examination,

including integration of services and messages and the challenge of positioning health and safety messages within the violence and dangers of their daily lives.

Despite the complexity of developing effective strategies and programs for high-risk youth and the seeming impossibility of the solution, the humanity of these youth must shine through. Despite their problems, they are still young people with the same concerns, vulnerabilities, and dreams shared by all youth. As they stated consistently in all groups, youth rate being loved, having a family, having a place to call home, being close to God, and feeling safe as most important.

NATIONAL ORGANIZATIONS, FOUNDATIONS, AND LOCAL PROGRAMS CONSULTED

Big Brothers/Big Sisters of America

Boys and Girls Clubs of America

Congress of National Black Churches

National 4-H

The Annie E. Casey Foundation

Carnegie Corporation of New York

Carnegie Council on Adolescent Development

Coalition of Community Foundations for Youth

Bell Multicultural High School, Washington, DC

Boys and Girls Club of Greater Washington/Eastern Branch, Washington, DC

Challengers Boys and Girls Club, South Central Los Angeles, CA

Chicago Urban League, Chicago, IL

City Lights Alternative School, Washington, DC

Montgomery County Prevention Center, Rockville, MD

SEA Possible, Los Angeles, CA

Southern California Indian Center, Los Angeles, CA

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- ❒ Office of Minority Health
- ❒ Office on Smoking and Health, Centers for Disease Control and Prevention
- ❒ Office of the Surgeon General

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- ❒ National Highway Traffic Safety Administration

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